

PSYCHIATRIC ILLNESS AND HEALTH

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'*Salus populi suprema est lex.*'—Cicero. De Legibus, Bk. 3, 3, 8.

Psychiatric illness, merges at some of its boundaries with healthy behaviour, a characteristic in which it does not differ essentially from other illness. Perhaps, however, the profession as a whole has done less to clarify the need to distinguish the degrees of *psychological* change encountered in *ordinary* living from those that are pathological. Symonds (1941) discusses this question in relation to affective disorder, since living is a variably anxious process and most of us have moments of despondency or gloom, sometimes relieved by social activity, entertainment or the encouragement and sympathetic ears of our friends.

Disturbances such as depressive self-reproach or unworthiness of a delusional nature may provide examples, for when they lead to a desire for punishment rather than treatment on the part of the patient, this may be difficult to distinguish from justifiable remorse, an emotion which fluctuates in the same way as depressive illness does, but which is none the less a reaction which most people of 'character' (Woodworth and Marquis, 1949) prefer to manage without medical help if they are able.

Clear thinking is perhaps particularly important on such questions since difficulties in delineating these illnesses may result in as much psychiatric disorder going untreated, as there may be treatment given to those who should not really be regarded as sick.

Too much *concern* over the latter possibility, however, tends to lead to patients—not themselves in the best frame of mind to combat such an attitude—accepting that such disease has to be fought alone. This is as undesirable as underestimating the need for personal effort, whether in living or in psychological treatment, and can only be avoided by distinguishing clearly between illness and variations in normal personality make-up or behaviour, so that the sick may get as fair a deal as the healthy.

Adults

Even the specialist at times may find it difficult

to draw the line between health and illness. In two patients, both of a reserved disposition and seen by the author in different mental observation wards, only the degree of detachment and the beginnings of a pressure sore during prolonged preoccupation with personal problems in one, and the fact that the other, a young Spanish immigrant in his twenties, had been supported by his family and had not left the four walls of his house for several years until driven to distraction by toothache, seemed in the end to warrant classification as abnormal findings.

Equally widespread must be difficulties in other examples, some of which appear in the daily press from time to time, of distinguishing hysteria from malingering,* neurasthenia from laziness, paranoia from selfishness and conceit,† and anxiety state from natural dread or from cowardice.‡ Conscientious persistence (or studious determination or creative preoccupation) may in the same way border upon obsession,§ energetic cheerfulness upon hypomania||, and reserved self-reliance upon schizoid detachment. Thus 'normal' qualities which are *socially desirable* may be in as much danger where concepts are not clear as those which are less so.

Adequate experience and training in differentiation, however, does result in specialists, able to disagree on occasion, agreeing in the main, although how much such findings may sometimes be due to similarity of training rather than to objectivity is perhaps still debateable (Eysenck, 1953).

Some of the relevant qualities of the illnesses in question, e.g. severity of mood change, are not things which can always be exactly assessed of course, any more than when evaluating the clinical

* Christie: *Daily Telegraph*, June 25, 1953; *Evening Standard*, June 24, 1953.

† Haigh: *Times*, July 20, 1949; *Evening Standard*, July 19, 1949. Hulme and Parker: *Daily Express*, August 28, 1954; *Evening Standard*, August 27, 1954.

‡ Lydon: *Evening Standard*, October 20 and 21, 1953.

§ Attention is being drawn here to the indiscriminate use, occasionally encountered, of such terms as 'rigid personality' and 'anal character.' Widely accepted criteria for *obsessional symptomatology*, as Zelmanowits (1953) has pointed out, were established as early as 1798.

|| Baker: *Daily Mail*, December 1, 1954.

features in a doubtful instance of any disease, and judgment has to depend essentially upon a human being's estimate. It is clinical experience, for example, which enables a surgeon to distinguish abnormal rigidity and guarding of the abdominal wall from the normal, and similar criteria apply in psychiatry, even to the extent of being able to express a positive opinion upon health (Curran, 1952), although recent developments in electro-myography may, in fact, help both surgery and psychiatry (*Brit. med. J.*, 1953, ii, 1422) in this respect.

Prophylaxis and Children

Prophylaxis, more concerned with the preservation of health than the treatment of illness, has to deal, however, with people who are not sick. In doing so it must inevitably interest itself in the degrees of severity and the range of influences (affecting persons from without), which can be accepted as the normal expectation. Separating normal from pathological influences in this way must exclude from psychotherapy the controls exerted by public opinion, economic circumstance, law and regulation* in society—including those implied in medical certification (Van den Bergh, 1954)—as well as the incentives, comfort or entertainment provided by private, charitable or statutory social enterprise, although such influences acting on healthy personalities, in the interests both of individual and of social hygiene, should, of course, be encouraged as much as is the preparedness of some to find their own explanations, reassurance or help when in difficulty, once attention has been drawn to facilities available, e.g. *Brit. med. J.*, 1953, ii, 1364, and *Lancet*, 1954, i, 512 and 1068.

Which patients will benefit by knowing something about their own structure and function however (*Lancet*, 1954, i, 1169, and *Brit. med. J.*, 1954, ii, 105), and how much should be known in such a context, still remains debatable in the light of such findings as those of Stewart (1953), although the high incidence of 'anxious obsessional' personality types attending a hospital outpatient department for skin diseases (Hall-Smith and Norton, 1952) seems to confirm that many patients with organic disease do come primarily for such explanation and reassurance, measures which incidentally, when called for in psychiatric rather than skin disease, may, in view of what has already been said of normal influences, be better managed by those who have had a liberal as much as a scientific education (*Lancet*, 1952, ii, 671). This is because human society is so complex and

varied. There must be many people whose lives might have revealed a much less fortunate pattern had not favourable social† influences of such a nature been at work at some critical juncture; just as inversely, there may have been many more of the homosexually interested for example, when such practices were not regarded as immature or perverse by the adults of a community, as Eysenck (1953) recalls.

In the case of children, still further social complexities exist both because parents, rather than adults in general, are responsible—although in gradually decreasing degree as the children grow older—for discipline, persuasion and encouragement as much as for explanation or reassurance, and also because they often have to act as intermediaries between the doctor and child in illness (Bierer, 1954).

It is, of course, possible, as already indicated, to assist parents or society in such matters affecting mental hygiene, through public health organizations, by advising them on the psychological aspects of upbringing or of social structure. This may account in fact for the Ministry of Health's (1950) suggestion to regional hospital boards that child guidance should be the concern of the school medical officer and educational psychologist, whilst children whose condition is pathological and requires therapeutic rather than preventative or educational measures (whether that education be part of parental or of school-teachers' function) should be seen at child psychiatric clinics attached to paediatric units.

Criminal and Delinquent Behaviour

Many people must have experienced degrees of such feelings as petulance or self-pity, more matters for discipline perhaps than sympathy since they lie in a direction in which criminal or delinquent behaviour occurs. Such behaviour can also be difficult at times to distinguish from psychiatric disorder, as the use of such terms as Munchausen syndrome (Asher, 1951) may indicate and as the following not dissimilar case may further illustrate.

A successful musician was admitted in late middle age for mental observation, having made an attempt to kill his wife and then himself. According to his fellow artists he had always had a higher opinion of himself than even his ability warranted. There was no history of depression prior to admission and in the ward he showed no other abnormality, appearing rather to be matter of fact when explaining that he had at last taken his action in view of the drain on his resources made by his wife's chronic physical illness and

* Except, of course, those laws and regulations appertaining only to the mentally ill.

† The word is used here in the same senses as Tinbergen (1951).

irritability. His course had been taken in preference to what were to him at the time presumably less acceptable alternatives, in view of his circumstances, and so after interviews with his family it seemed reasonable simply to discharge him to the care of friends to seek further advice on his problems.

Threatened or attempted suicide may, as in this case, throw the need to distinguish psychiatric disorder from criminal behaviour into relief, for suicide is, of course, illegal in its own right.* The difficulty can arise where unwanted pregnancy is the motivating factor, although the burden of other responsibilities must provide at times as many, if not more, such instances. A therapist under such circumstances in being prepared if need be to make it clear even to the patient, and to the parents or to others who may be responsible, that he considers the behaviour to be delinquent or criminal rather than medical,† does not, however, fear when doing so—as long as there are men like Paterson (1951) or Mullins (1953) in our midst—that sound *psychological* principles need cease to be applied should it become a matter for the law to deal with.

Sometimes the fact that psychiatric disorder and criminal behaviour may be associated together in the same patient produces difficulties of its own in evaluation and treatment, as in the man admitted for mental observation in a depressed, suicidal state, exhibiting 'functional' aphonia. At one point, schizophrenia was considered to be a possible diagnosis, so odd seemed his reserve once he could speak. Another account of events was obtained however, and it became apparent that the impression the patient gave of having delusions of persecution or of believing himself to be under supernatural influence, arose entirely from a perhaps understandable reticence in telling his full story. He finally admitted that, not long before, a neighbour outraged at finding him masquerading as a woman, seized an opportunity in the street to knock off his wig so that he was arrested, charged and fined. Following this reverse the patient developed attacks of aphonia and attended a general hospital for outpatient psychiatric treatment. In one particular emergency during this treatment he was seen in a casualty department and admitted to an observation ward, whence he was finally discharged to continue his outpatient therapy somewhat reassured no doubt in view of his earlier reticence, that doctors are not prevented from helping the sick as long as this does not interfere with the course of the law.

Not that the law is antagonistic to treatment of course, for the Criminal Justice Act, 1948, and the Children and Young Persons Act, 1933, with use of the McNaghton Rules, do provide for the protection and treatment of most psychiatric patients in the maximum amount of liberty compatible with reasonable protection for the public. This is valuable latitude where treatment is concerned, since patients can benefit from remaining in as normal an environment as possible. It is true, of course, that Case Law has established that 'nature and quality' in the McNaghton Rules refers only to the physical nature of a criminal act (Hailsham, 1952) and if this interpretation continues there is no way in which patients, whose general judgment of a situation is disturbed by a pathological disorder of affect or by moral defect* (Mental Deficiency Act, 1927, Section 1 (d)) can be held other than responsible by a jury, although the morally defective may in fact escape a death penalty as the result of medical examination after sentence†, especially since this mental condition by definition is then still likely to be present. Affective disorder, however, may by that time have dispersed so that prisoners with this condition may not therefore escape, and this seems all the more incongruous because patients with affective disorder do escape the death penalty where the crime is infanticide and not murder (Infanticide Act, 1938).

It is not always necessary, however, to make new laws, as with the introduction of the Infanticide Act, to keep pace with our increasing tolerance and understanding. A change in interpretation as has occurred in relation to therapeutic termination of pregnancy may be sufficient. Any change of this nature relative to disorder of affect in general will presumably depend in part upon demonstration that simulated and genuine emotional abnormality can be differentiated, as well as may psychopathic personality (Lewis, 1950) and illness.

Naturally the question of responsibility is not confined to capital offences‡, e.g. *Lancet*, 1949, ii, 1158, and 1954, ii, 286. Allen (1952) and Palmer (1952) mention the difficulty, especially in relation to post-epileptic automatism, and Pickworth (1952) draws renewed attention to the confusion present as part of this mental state. Inevitably it may be difficult to establish after a criminal act that such confusion was present, especially if there were no witnesses, although a strong likelihood can sometimes subsequently be

* Heath: *Evening Standard*, September 25, 1946; *Daily Express*, September 26, 1946. Straffen: *Daily Express*, July 25, 1952; *Daily Telegraph*, July 24, 1952.

† Straffen: *Daily Telegraph*, August 30, 1952.

‡ *Brit. med. J.*, 1954, 2, 1175.

* *Brit. med. J.*, 1954, 2, 1493.

† E.g. in some instances of homosexuality or public indecency or threatened violence.

inferred from the clinical history considered together with E.E.G. findings (Hill and Sargant, 1943).

Whether an act is to be regarded as 'automatic' or not, however, must presumably depend upon the state of the patient's general consciousness at the time, a state which we now know does follow the frequency of cortical electrical rhythms (Hill, 1950). There are various levels of consciousness with their accompanying clinical and electrical findings, so that the question becomes one of the level of consciousness which is compatible with any particular degree of legal responsibility, for the law recognizes that the capacity for responsible behaviour does vary.

This it particularly does with regard to age. For example, 'No child under the age of 8 years can be guilty of any offence,' and 'Sentence of death shall not be pronounced on or recorded against a person . . . if . . . at the time the offence was committed he was under the age of 18 years,' and there are many intermediate degrees between these extremes in the application of legal 'deterrents' (*Lancet*, 1952, ii, 721). Since the electrical changes accompanying increasing consciousness parallel to some extent those of growing children (Hill, 1950) they should therefore, theoretically at least, in combination with clinical findings prove useful in deciding within broad limits what degree of legal responsibility is to be applied in a particular instance, although this is not necessarily to suggest that a person in gradually passing through the stages of diminishing consciousness always behaves as he did earlier in his own childhood. The similarity is rather in the degree of adult awareness and therefore responsibility with which actions are undertaken, whether in fact a person *knows* what he is doing and can be expected to *know* that it is wrong.

There is one particular group, likely at times to come to the notice of the law, in which clinical and electrical findings have been found in a correlation which might prove of particular value in this way (Rey, Pond and Evans, 1949). The clinical findings were not unlike those found in Eysenck's (1947) 'hysteria' factor, and Rey, Pond and Evans, in attributing this to a failure of maturation, also draw attention to Hill's observation in an earlier study, of a similarity to behaviour in children. The electrical findings in Rey, Pond and Evans series, Hill (1952) likewise considers to be due to maturation defects of the nervous system, so that theoretically again it should be possible to establish both clinically and electrically the degree of responsibility reasonably to be expected from this group. If, as a result, it were found, however, that this group should no longer be held responsible for certain classes of action,

further problems arise (as is, of course, widely recognized) because physical strength and reproductive maturity need not be delayed in the same way as psychological development.

In a different group, i.e. the feeble-minded, of whom Kreezer (1937) writes 'there was distinct evidence of a variation in the properties of the electro-encephalogram with variation in the mental age level,' the concept of mental age as opposed to chronological age might also be useful when assessing diminished legal responsibility (*Brit. med. J.*, 1954, ii, 250), although, of course, this would then only be likely to be applicable to those between the mental ages of 8 (the age of legal responsibility) and about 12 (the upper limit of feeble-mindedness) and would then automatically exclude the death penalty for the feeble-minded.

Mental ages are at times assessed both clinically and psychometrically, and when assessed by Binet tests they are 'statistically and methodologically comparable' to the Social Ages of the Vineland Social Maturity Scale (Doll, 1947). Social maturity as measured by this scale may seem a criterion to be preferred to intelligence as measured by tests, when assessing capacity for responsible action; but if either were to be used, it may be important to bear in mind that both the Vineland scale and Stanford-Binet (Terman and Merrill, 1937) intelligence tests were standardized on foreign populations (Burt, 1947).

Summary

Attention is drawn to the need to distinguish psychiatric disturbance clearly from the degrees of psychological change encountered in healthy behaviour. This theme is developed particularly with regard to mental hygiene, the management of children and the evaluation of criminal responsibility. The concept of 'levels of consciousness, with their accompanying psychological and electrical findings,' is used in an attempt to clarify certain aspects of such responsibility.

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suggest that the common bile duct has to accommodate an infective bile which can set up inflammatory changes in its walls. In addition, a history prior to cholecystectomy of attacks of intermittent fever (Charcot type) is suggestive of duct changes which may end in obliterative cholangitis. In cases where numerous stones are found at cholecystectomy, or where the bile when examined is gritty, muddy or dirty-looking, a cholangiogram is worth carrying out on the table. It makes doubly sure (in addition to exploring the common bile duct) that there is no obstruction of the duct at its entrance to the duodenum. In addition it gives the surgeon the satisfaction of

knowing that there is no question of injury to the duct should jaundice develop subsequent to the cholecystectomy.

Chronic obliterative cholangitis may develop in neglected gall bladder cases, and cholecystectomy should be advised in the early stages of cholecystitis in order to prevent this pathological condition developing.

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